RIGHTS REGARDING TREATMENT PLANS FOR DEPARTMENT OF MENTAL HEALTH CONTINUING CARE SERVICES

A treatment plan determines the services you receive from a facility or program. This pamphlet discusses treatment plans for continuing care services which are operated by, or provided through contract with, the Department of Mental Health (DMH). This pamphlet discusses both individual service plans (ISPs) and program specific treatment plans (treatment plans). An ISP describes the range of services the individual receives from all providers, while a treatment plan identifies the specific services provided by a particular facility or program.

I. ELIGIBILITY FOR DMH CONTINUING CARE SERVICES

Individuals have the right to an ISP when they are eligible for DMH continuing care services and some or all of the services they need are available.[1] DMH continuing care services are community-based services contracted for or operated by DMH; they do not include services of brief duration, outpatient services, court evaluations, or acute mental health services, such as crisis intervention or emergency screening.[2]

II. ISP MEETING

As soon as an individual is determined eligible, DMH will assign a case manager.[3] Within 20 days, the case manager must formally assess the individual's service needs.[4] Within 10 days of completing this assessment, the case manager must convene a meeting to prepare an ISP.[5] The case manager must invite the client, any legally authorized representatives of the client,[6] current and potential service providers, DMH staff, and anyone else, including family members, whom the client or their representative requests be invited.[7] Each service provider who will administer DMH continuing care services must submit a written treatment plan to the case manager no more than 20 days after this initial ISP meeting.[8]

III. THE ISP

The case manager must prepare a written ISP within 25 days of the initial ISP meeting, and include the treatment plans prepared by the service providers.[9] An ISP must be individualized, identifying the client's goals, strengths, and needs, as well as all DMH services and programs that address those needs.[10] Services identified in the ISP, to the greatest extent possible, must be consistent with the client's preferences, and provided in the least restrictive setting.[11]

IV. TREATMENT PLANS

Treatment plans included in the ISP should be based on information gathered during the application process as well as the assessment of service needs.[12] These plans must include both long and short-term treatment objectives (including the criteria and a timeline for gauging achievement), as well as the specific treatment modalities that will be used.[13]

DMH regulations include additional requirements regarding treatment plans specific to the type of facility or program.

- Inpatient facilities licensed by, funded by or contracted with DMH (including intensive residential treatment programs) must prepare a written treatment plan for each patient.[14] A representative from each facility discipline (for example, a nurse, psychiatrist, psychologist, rehabilitative specialist, and social worker) must contribute to the plan.[15] The plan must be developed with the maximum possible participation of the patient or the patient's legally authorized representative.[16] Staff must conduct a periodic written evaluation of treatment progress, at which time the responsible clinicians must record significant modifications of the plan and the rationale for them.[17]

- Community-based programs licensed by, funded by or contracted with DMH must develop and implement a treatment plan for each resident.[18]

V. ACCEPTING OR REJECTING THE ISP

Once the ISP is complete, the case manager sends it to the client or the client's legally authorized representative for acceptance or rejection.[19] If the client or the client's legally authorized representative fails to object to the ISP within 20 days of receipt, the plan is considered accepted.[20] The ISP will be implemented as soon as it is accepted.[21] The client or the client's legally authorized representative may reject all or part of the ISP, in which case the case manage must provide notice within five days of the right to meet and discuss potential modifications to the plan.[22] If that meeting fails to yield an agreement, the client has the right to appeal the ISP.[23] The appeal may be filed by the client, a legally authorized representative, or if one does not exist, a person designated by the client to act as a representative.[24] If portions of the ISP are accepted, they may be implemented (when appropriate) even when an appeal is pending on other portions.[25]

VI. APPEALING THE ISP

Some issues that may be brought up on appeal include:

- Whether the assessment, the ISP or the treatment plans meet regulatory requirements;

- Whether the assessment is sufficient to serve as the basis for the ISP or the treatment plans;

- Whether the assessment, the ISP, or the treatment plans are reasonable in the circumstances;

- Whether the goals, objectives, and timelines in the ISP or treatment plans are appropriate and reasonably related to the client's needs, as identified in the application and assessment process;

- Whether the services identified in the assessment, ISP, or treatment plans are consistent with the client's needs, and meet those needs in the least restrictive setting possible;

- Whether proposed modifications of the ISP, the treatment plan, services, or the service provider are reasonable in the circumstances;

- Whether the regulatory procedures for developing the ISP and treatment plans have been followed.[26]

An appeal is filed by submitting a written statement to the DMH Area Director, indicating the issue being appealed and the basis for the appeal.[27] An appeal must be filed within 30 days; however, the Area Director may accept an appeal after 30 days for good cause.[28]

Within 20 days after an appeal is filed, the Area Director or a designee will hold an informal conference with the client, their legally authorized representative (if any), the case manager, the program director (if appropriate), and other invited persons.[29] If this conference fails to yield a resolution, the Area Director or designee will identify both the issues of fact that are not in dispute and those that remain the subject of the appeal.[30] The Commissioner (or a designee) may waive this informal conference if the appealing party agrees to do so.[31]

VII. HEARING

If the issue remains unresolved, within 10 days of the conference or its waiver the client may petition the Commissioner or designee for a hearing.[32] Within 10 days of that petition, the Commissioner must appoint a hearing officer, who will schedule a hearing date that is agreeable to the parties.[33] The hearing must be consistent with Massachusetts statutes, including chapter 30A of the Massachusetts General Laws,[34] DMH regulations, and the state's informal fair hearing rules.[35] The hearing officer must issue a written decision within 20 days of the close of the hearing.[36] The parties have the right to petition for re-hearing or to appeal the decision (of either a hearing or a re-hearing) to the Superior Court.[37] Appeals to the Superior Court must be filed within 30 days of the receipt of the decision of a hearing or a re-hearing.[38]

VIII. RE-HEARING

A petition for re-hearing may be made on the following grounds:

- Discovery of new evidence likely to materially affect the appealed issues;
- That the hearing was conducted in a way that was inconsistent with DMH regulations or was prejudicially unfair to a party;
- That the decision was based upon inappropriate standards or contained other errors of law;
- That the decision was unsupported by any substantial evidence.[39]

Throughout the appeal process, DMH has the burden of showing that its proposed plan is the most appropriate in the circumstances.[40] The standard of proof on all issues is a preponderance of the evidence.[41] This means that if the client can show that it is more likely than not that the evidence supports a different plan, he or she should prevail on appeal (whether it is at the hearing, re-hearing, or Superior Court level).[42]

The portions of an ISP that are in controversy will not be implemented during the appeal process, even if the proposal is for the modification or termination of an existing plan.[43] However, in an emergency, or when necessary to comply with state contracting requirements, an existing treatment plan may be modified without the consent of the individual or his or her legal guardian.[44] The

emergency must pose a serious threat to the health, mental health, or safety of the client or others in order to make such a modification allowable.[45]

IX. PERIODIC REVIEW OF TREATMENT PLANS

Massachusetts statute and DMH regulations require the periodic review of treatment plans:

- Inpatient facilities licensed by, operated by or contracted with DMH (including intensive residential treatment programs) must conduct a periodic review of the treatment plan and progress of each adult inpatient upon admission, during the first 3 months, during the second 3 months, and annually thereafter, and must review minors' plans quarterly.[46] The facility must provide reasonable advance written notice of the periodic review to the individual, the individual's legally authorized representative, and, unless the individual knowingly objects, to the individual's nearest living relative; the notice must give the date of the review and invite participation.[47] For each periodic review, a senior clinician must evaluate the individual's competency to remain on or apply for conditional voluntary admission, to consent to ordinary or extraordinary treatment (including antipsychotic medications), and to manage his or her funds.[48] Alternatives to hospitalization also should be evaluated.[49] The person in charge of conducting the review must enter in the patient's record the following: the information presented; the reasons for the determination that you need continuing inpatient care and treatment; and the alternatives to hospitalization which were considered and why they were rejected.[50]

- Community-based programs must conduct periodic reviews of each resident's treatment plan and progress within 3 months of admission, within 6 months of admission, and annually thereafter.[51]

Periodic reviews for individuals within the care of DMH must include, but are not necessarily limited to:

- A thorough clinical examination, including a review of any treatment, response to treatment, and medications administered;

- An evaluation of the legal competency of the person and the need for a guardian or conservator;

- Any alternatives to continued hospitalization or residential care;

- Unless a guardian or conservator has been appointed, an evaluation of competency to manage funds (and, if the team finds the individual unable to manage certain funds, a plan for managing those funds).[52]

Mental Health Legal Advisors Committee
399 Washington Street, 4th Floor
Boston, MA 02108
(617) 338-2345
(800) 342-9092

ENDNOTES

1. 104 CMR 29.06(2)(b)1; 104 CMR 29.08(4).
2. 104 CMR 29.02.
3. 104 CMR 29.05(1).
4. 104 CMR 29.06(1)(a); *see* 104 CMR 29.06(1)(b)-29.06(1)(e).
5 104 CMR 29.06(2)(b)1.
6. A legally authorized representative is a guardian or other fiduciary granted applicable authority by a court of competent jurisdiction or, in the case of a minor, the parent(s) or other individual or entity with legal custody. 104 CMR 25.03.
7. 104 CMR 29.06(2)(b)1.
8. 104 CMR 29.07(2).
9. 104 CMR 29.08(4).
10. 104 CMR 29.06(2)(a)1.
11. 104 CMR 29.06(2)(a)2.
12. 104 CMR 29.07(3).
13. *Id.*
14. 104 CMR 27.10(5).
15. *Id*.
16. *Id.*
17. *Id.*
18. 104 CMR 28.14(3)(a).
19. 104 CMR 29.09(1).
20. 104 CMR 29.09(1)(b).
21. 104 CMR 29.09(1)(a).
22. 104 CMR 29.09(1)(c).
23. 104 CMR 29.09(1)(d).
24. 104 CMR 29.15(1)(d).
25. 104 CMR 29.09(2).
26. *See* 104 CMR 29.15(2).
27. 104 CMR 29.15(4)(a).
28. 104 CMR 29.15(4)(b).
29. 104 CMR 29.15(4)(c)1.
30 *Id*.
31. 104 CMR 29.15(4)(c)3.
32. 104 CMR 29.15(5).
33. *Id*.
34. *Id*.
35. *Id*.
36. 104 CMR 29.15(5)(h).
37. 104 CMR 29.15(5)(h)1; 104 CMR 29.15(8).
38. 104 CMR 29.15(8).
39. 104 CMR 29.15(6)(a).
40. 104 CMR 29.15(7)(b)2.
41. 104 CMR 29.15(7)(a).

42. *See id.*
43. *See* 104 CMR 29.10(5)(c), 104 CMR 29.11(3); 104 CMR 29.13(3).
44. 104 CMR 29.11(3)(b).
45. *Id.*
46. 104 CMR 27.11(1); *see also* Mass. Gen. L. ch. 123, § 4.
47 Mass. Gen. L. ch. 123, § 4; 104 CMR 27.11(2).
48 104 CMR 27.11(4).
49 104 CMR 27.11(5).
50 104 CMR 27.11(6).
51 104 CMR 28.14(3)(a), (b).
52. Mass. Gen. L. ch. 123, § 4; *see also* 104 CMR 27.11(3)-27.11(5) (periodic reviews at inpatient facilities).